



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TWELVE OAKS HOSPITAL
C/O LAW OFFICE OF P MATTHEW ONEILL
6514 MCNEIL DR BLDG 2 STE 201
AUSTIN TX 78729

Respondent Name

TPCIGA FOR COLONIAL CASUALTY INS CO

Carrier's Austin Representative Box

Box Number 50

MFDR Tracking Number

M4-98-B020-01

MFDR Date Received

April 23, 1998

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please be advised that Colonial Casualty [illegible] in paying claims per the TWCC per diem rate that has been invalidated. Payment should be 85% of total charges, which we consider as fair and reasonable."

Amount in Dispute: \$28,350.70

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the hospital has not provided any evidence that this payment was not fair and reasonable. Therefore, it is our position the hospital has been paid an amount that is equal to or exceeds the payment required under rule 413.011, Texas Labor Code."

Response Submitted by: Colonial Casualty Insurance Company, 12850 Spurling Drive, Suite 250, Dallas Texas 75230

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
July 28, 1997 to August 1, 1997	Inpatient Hospital Services	\$28,350.70	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code §133.305, effective June 3, 1991, 16 *Texas Register* 2830, sets out the procedures for resolving medical fee disputes.
2. Former 28 Texas Administrative Code §134.1(f) effective October 7, 1991, 16 *Texas Register* 5210, sets out the reimbursement guidelines for the services in dispute.
3. Former 28 Texas Administrative Code §134.401, effective August 1, 1997, 22 *Texas Register* 6264, sets out the fee guidelines for acute care inpatient hospital services.

4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. The services in dispute were reduced/denied by the respondent with the following payment exception codes:
 - 270 – NO ALLOWANCE HAS BEEN RECOMMENDED FOR THIS PROCEDURE/SERVICE/SUPPLY PLEASE SEE SPECIAL *NOTE* BELOW
 - 426 – REIMBURSED TO FAIR AND REASONABLE
 - 255 – BASED ON THE AVAILABLE INFORMATION, THIS CHARGE DOES NOT APPEAR TO BE APPLICABLE IN THIS CASE.
 - M – Reduced to Fair and Reasonable
 - T – Not According to Treatment Guidelines

Findings

1. The requestor provided inpatient hospital services on August 1, 1997 with reimbursement subject to the provisions of the Division's former *Acute Care Inpatient Hospital Fee Guideline* at 28 Texas Administrative Code §134.401, effective August 1, 1997, 22 *Texas Register* 6264. Review of the submitted documentation finds that the applicable length of stay was 1 day. The type of admission is surgical; therefore, the standard surgical per diem amount of \$1,118.00 multiplied by the length of stay of 1 day yields a reimbursement amount of \$1,118.00.
2. Additionally, the requestor provided inpatient hospital services from July 27, 1997 through July 31, 1997 that were not identified in an established fee guideline during the dates the services were rendered. The former agency's *Acute Care Inpatient Hospital Fee Guideline* at 28 Texas Administrative Code §134.400, 17 *Texas Register* 4949, was declared invalid in the case of *Texas Hospital Association v. Texas Workers' Compensation Commission*, 911 *South Western Reporter Second* 884 (Texas Appeals – Austin, 1995, writ of error denied January 10, 1997). As no specific fee guideline existed for acute care inpatient hospital services during the time period that the disputed services were rendered, the 1991 version of 28 Texas Administrative Code §134.1(f) applies as the proper Division rule to address fee payment issues in this dispute, as confirmed by the Court's opinion in *All Saints Health System v. Texas Workers' Compensation Commission*, 125 *South Western Reporter Third* 96 (Texas Appeals – Austin, 2003, petition for review denied). 28 Texas Administrative Code §134.1(f), effective October 7, 1991, 16 *Texas Register* 5210, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, sec. 8.21(b), until such period that specific fee guidelines are established by the commission."
3. The former Texas Workers' Compensation Act section 8.21 was repealed, effective September 1, 1993 by Acts 1993, 73rd Legislature, chapter 269, section 5(2). Therefore, for services rendered on or after September 1, 1993, the applicable statute is the former version of Texas Labor Code section 413.011(b), Acts 1993, 73rd Legislature, chapter 269, section 1, effective September 1, 1993, which states, in pertinent part, that "Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commission shall consider the increased security of payment afforded by this subtitle."
4. Review of the submitted documentation finds that:
 - The requestor's position statement asserts that "Payment should be 85% of total charges, which we consider as fair and reasonable."
 - The requestor did not submit documentation to support that payment should be 85% of total charges.
 - The Division finds that a reimbursement methodology based upon a percentage of billed charges does not produce an acceptable payment amount. Such a reimbursement methodology would leave the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs. Therefore, a reimbursement amount that is calculated based upon a percentage of a hospital's billed charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
 - The requestor does not discuss or explain how payment of the amount sought would result in a fair and reasonable reimbursement for the services in this dispute.
 - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement for the disputed services.
 - The requestor does not discuss or explain how payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement for dates of service July 28 through July 31, 1997 is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment for these services cannot be recommended.

5. The submitted documentation supports a reimbursement amount of \$1,118.00. The insurance carrier paid \$10,241.30. No additional reimbursement is recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Grayson Richardson Medical Fee Dispute Resolution Officer	July 23, 2013 Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.